

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1772 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01766

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> <div style="text-align: center;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Nathaniel</u> Middle <u>Beverly</u> Last <u></u>				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years and birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Raymond Beverly Lusby</u> Address <u>Lusby</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>hypertension</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead on floor of home</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20c. TIME OF INJURY Month, Day, Year <u>11:00</u> p.m. <u>2/24</u> 19 <u>60</u>			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. City or town <u>Lusby</u>				(County) <u>Calvert</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. Ward</u>				DATE SIGNED <u>2/24/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-27-60</u>		22b. DATE THEREOF <u>2-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Solomons</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. T. Sewell, Prince Fred</u>				24a. REC'D BY REGISTRAR <u>DATE 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Lewis</u>	

TO DEPUTY MEDICAL EXAMINER: If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AT 500MIL/HR—HILAH TO THE WATERSIDE STATE ORATORY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Michael</u> First <u>Zee</u> Middle <u>Brown</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1960</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>E</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 2, 1959</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months <u>7</u> Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Brown</u>				14. MOTHER'S MAIDEN NAME <u>Hilda Chew</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Thomas Brown</u> Address <u>Huntingtown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory disease</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>H W Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>2/22/60</u>	
EXAMINER'S NAME (Type) _____				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Satanst Church Cem</u>		22d. LOCATION (City, town, or county) <u>Huntingtown, Md.</u> (State) <u>CO</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Zeroph Berry</u>				ADDRESS <u>Huntingtown, Md.</u>		24a. REC'D BY REGISTRAR _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>FEB 24 '60</u>				2064409XVS					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1774

CERTIFICATE OF DEATH

01768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X St. Leonard</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Henry Coates</u>				4. DATE OF DEATH Month Day Year <u>February 25</u> <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22, 1885</u>		9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Coates</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca F. Savoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Josephine C. Reynolds, St. Leonard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure due to</u> <u>420.1</u> DUE TO <u>Coronary occlusion -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 23</u> , 19 <u>60</u> , to <u>Feb 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 25</u> , 19 <u>60</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>St Leonard</u>		DATE SIGNED <u>2/26</u>	
PHYSICIAN'S NAME (Type) <u>P. E. Sewell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-27-60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		22d. LOCATION (City, town, or county) (State) <u>mutual md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Frederick, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1770

<p>1. Name of deceased: <u>JOHN J. JONES</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>January 15, 1900</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>February 10, 1950</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Myocardial infarction</u></p>		<p>8. Duration of illness: <u>2 days</u></p>	
<p>9. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Name of hospital: <u>St. Louis Hospital</u></p>	
<p>11. Name of funeral home: <u>None</u></p>		<p>12. Name of cemetery: <u>None</u></p>	
<p>13. Name of informant: <u>John J. Jones</u></p>		<p>14. Address of informant: <u>1234 Main St., St. Louis, Mo.</u></p>	
<p>15. Signature of informant: <u>[Signature]</u></p>		<p>16. Signature of physician: <u>[Signature]</u></p>	
<p>17. Date of filing: <u>February 15, 1950</u></p>		<p>18. File number: <u>1770</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1775

CERTIFICATE OF DEATH

01769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randle Cliffs</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma L. Roberts</u> First Middle Last		4. DATE OF DEATH <u>Feb 5 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12 1877</u> 9. AGE (In years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Louis Fiedler, Randle Cliffs Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia C.V.R. disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2 Jan 1949</u> to <u>4 Feb 1960</u> that I last saw the deceased alive on <u>4 Feb 1960</u> , and that death occurred at <u>2:05 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Huntingtown Md 2-5-60</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. J. WEEMS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-7-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Harmony</u>	22d. LOCATION (City, town, or county) (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Bulfinch Funeral Home, Owings Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 1960</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1776

CERTIFICATE OF DEATH

01770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 15th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Arthur Louis Espey				4. DATE OF DEATH Month February Day 23 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/17/72	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 23 Days 19 Hours 60		IF UNDER 24 HRS. Months 23 Days 19 Hours 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Office Pressman U. S. Gov.				10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Clay Espey				14. MOTHER'S MAIDEN NAME Mary Elizabeth Bridgett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Henry Clay Espey, Washington, D. C.			
17. INFORMANT Henry Clay Espey, Washington, D. C.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure due to Hypertension C C of DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 hours (c) 10 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 23, 1960 to Feb 23, 1960 , that I last saw the deceased alive on Feb 23, 1960 , and that death occurred at 5:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Leonards, Maryland DATE SIGNED Feb 23, 1960							
ACTUAL SIGNATURE Roberto de Villarreal M.D. St. Leonards, Maryland							
PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company -Washington, DC				24a. REC'D BY REGISTRAR DATE FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1777

CERTIFICATE OF DEATH

01771

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Salisbury</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Salisbury</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonards</u>				c. LENGTH OF STAY IN 1b <u>13 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph George GROENINGER</u>				4. DATE OF DEATH Month Day Year <u>Feb. 19 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 22 1884</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foreign Service</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John L. Groeninger</u>				14. MOTHER'S MAIDEN NAME <u>Anne Jennings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Valda Groeninger, St. Leonards Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURE AORTIC ANEURISM</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>PAUL C. JETT</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>PAUL C. JETT</u>				<u>PRINCE FREDERICK MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb. 23, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>A.G. Harrison, Baltimore, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01772											
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Calvert						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lower Marlboro					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lower Marlboro						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 1						
3. NAME OF DECEASED (Type or print) First OTHA Middle BEAM Last GUPTON					4. DATE OF DEATH Found February 25th, 1960						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 7, 1919		9. AGE (In years last birthday) 40 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau of Weapons		10b. KIND OF BUSINESS OR INDUSTRY Erco Division		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME Tommy Gupton					14. MOTHER'S MAIDEN NAME Mamie Pearce						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W W 11 none		17. INFORMANT Address Mrs Pauline Taylor Castalia N C Route 1							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 824X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute alcoholism										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) Car went off end of pier								
20c. TIME OF INJURY Month, Day, Year XXXX 2/25/19 60			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) Lower Marlboro		(County) Calvert		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
					DATE SIGNED 2/29/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 3/3/60		22c. NAME OF CEMETERY OR BURIAL PLACE Wood Baptist Church		22d. LOCATION (City, town, or country) (State) Franklin County North Carolina		
23. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.					24a. REC'D BY REGISTRAR DATE MAR 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus				

2582

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1779

CERTIFICATE OF DEATH

01773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unknown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Hanson</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1894</u>	9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Bona Kentucky</u>	
13. FATHER'S NAME <u>Samuel Griffith Hanson</u>				14. MOTHER'S MAIDEN NAME <u>Nickerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Sharon B. Jones (U.S.A.) Norfolk, Va.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> DUE TO (c) <u>UPPER RESPIRATORY INFECTIONS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 12</u> , 19 <u>60</u> , to <u>Feb 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>60</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C. Jett</u>				ADDRESS (Street, city or town, state) <u>Prince Frederick</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>				M.D. <u>PRINCE FREDERICK MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Feb. 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Markumson</u>				ADDRESS <u>Port Republic, Md</u>		24. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>	
				25. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1234 CERTIFICATE OF DEATH

Reg. Off. No.

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF FUNERAL HOME

NAME OF CEMETERY

CERTIFICATE OF DEATH

1780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Benjamin</i> Last <i>Laveille</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 26, 1868</i>
9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired State Road</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Lusby, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James Laveille</i>		14. MOTHER'S MAIDEN NAME <i>Anne S. Breeden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Louise Laveille, Lusby, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive C.V.R. disease</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2-4</i> , 1960, to <i>2-11</i> , 1960, that I last saw the deceased alive on <i>2-11</i> , 1960, and that death occurred at <i>3:25</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. H. Green</i>		ADDRESS (Street, city or town, state) <i>Huntington Md</i> DATE SIGNED <i>2-12-60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Feb 13, 1960</i>	<i>St. Paul's Cemetery</i>	<i>Lusby, Calvert Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. G. Barbness & Son - Mutual, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 16 '60</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1781

CERTIFICATE OF DEATH

Reg. Dist. No.

01775

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings			
c. LENGTH OF STAY IN 1b 3 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORA Middle VIRGINIA Last MARQUESS				4. DATE OF DEATH Month February Day 10 Year 1960			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1900		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Cochran				14. MOTHER'S MAIDEN NAME Ann Stinnett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Chester Stinnett, Prince Frederick		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 25220 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thyroid Storm DUE TO (c) Thyrototoxicosis						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 59 , to Feb , 19 60 , that I last saw the deceased alive on Feb 10 , 19 60 , and that death occurred at 10:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Prince Frederick, Md. DATE SIGNED 2-11-60							
ACTUAL SIGNATURE Page C. Jett M.D.							
PHYSICIAN'S NAME (Type) Page C. Jett				Prince Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 13/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Owings, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home				ADDRESS Owings, Md.		24a. REC'D BY REGISTRAR DATE B 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01776

Calvert County 1782

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Huntingtown</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glyndon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kerry nursing home</u>		d. STREET ADDRESS <u>md</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>S.</u> Last <u>Smack</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 April 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Acc.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thos Tarr</u>		14. MOTHER'S MAIDEN NAME <u>Ester Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-8077</u>	
17. INFORMANT <u>Herman Smack Pr Fred. md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2 Aug.</u> , 19 <u>59</u> , to <u>3 Feb.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2 Feb.</u> , 19 <u>60</u> , and that death occurred at <u>11:45</u> p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Weevers</u>		M.D. <u>Huntingtown, md</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>2/4/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 6, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) <u>Pikesville, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons</u>		ADDRESS <u>Reisterstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. DATE</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> - 1783 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co Hospital</u>		d. STREET ADDRESS <u>1 Prince Frederick</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harold</u> <u>M</u> <u>Smith</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/31 '86</u>
9. AGE (In years less birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phil Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>Phil Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Milton Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ernest Collett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Chart</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Effusion of serous cavity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found pneumonia in yard of home by wife</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/20/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb. 23, 1960</u>		22b. DATE THEREOF <u>Feb. 23, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. G. Parkner & Son</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED 1735		PLACE OF DEATH HOME	
SEX MALE		AGE 35	
RACE WHITE		OCCUPATION DRIVER	
DATE OF DEATH 1935		TIME OF DEATH 10:30 AM	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH 1900	
NAME OF MOTHER MARY J. [illegible]		NAME OF FATHER [illegible]	
MARITAL STATUS SINGLE		PREVIOUS MARRIAGES NONE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
MEDICAL HISTORY [illegible]		SOCIAL HISTORY [illegible]	
PHYSICAL EXAMINATION [illegible]		LABORATORY EXAMINATIONS [illegible]	
SIGNATURE OF EXAMINER [illegible]		SIGNATURE OF WITNESS [illegible]	
OFFICIAL SEAL [illegible]		COUNTY OF DEATH BALTIMORE	

1935
 BALTIMORE
 DEPARTMENT OF HEALTH
 MEDICAL EXAMINER'S OFFICE
 100 N. CALVERT ST.
 BALTIMORE, MD. 21202

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/55

MASSACHUSETTS DEPARTMENT OF HEALTH—BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME LAST FIRST MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		AGE YEARS MONTHS DAYS	
OCCUPATION PLACE OF BIRTH		PLACE OF DEATH	
MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DATE OF DEATH	
TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH (To be filled by the Medical Examiner)			
MANNER OF DEATH (To be filled by the Medical Examiner)			
SIGNATURE OF MEDICAL EXAMINER (To be filled by the Medical Examiner)			
DATE OF SIGNATURE			
OFFICE OF THE MEDICAL EXAMINER (To be filled by the Medical Examiner)			
CITY OF BOSTON			

RECEIVED
 DEPARTMENT OF HEALTH
 BOSTON
 MAY 10 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G257 2-29-60 et

Reg. Dist. No.

01779

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> 1785 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smethers</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smethers</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virgil Lorne Turner</u> First Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Turner</u>		14. MOTHER'S MAIDEN NAME <u>Emma Cor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1918-1919</u>		16. SOCIAL SECURITY NO. <u>220-01-1311</u>	
17. INFORMANT <u>Joe C. Cotton</u> Address <u>Quincy Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 322.2 DUE TO <u>alcohol</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in yard of home</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>2-21-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u> ADDRESS <u>Quincy Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Solomons, Md.</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>A. Woodburn</u> Middle <u>—</u> Last <u>—</u>		4. DATE OF DEATH <u>Feb.</u> Month <u>20</u> Day <u>1960</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant - Baltimore</u>	9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Solomons, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry M Woodburn</u>		14. MOTHER'S MAIDEN NAME <u>Mary M Filer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-22-2594</u>	
17. INFORMANT <u>Joseph Woodburn, Solomons, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Robur pneumonia - Uremia - Toxemia</u> <u>456X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pericarditis nodosa</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 13, 1960</u> to <u>Feb 20, 1960</u> , that I last saw the deceased alive on <u>Feb 20, 1960</u> and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Solomons, Md.</u> DATE SIGNED <u>2/21/60</u>	
PHYSICIAN'S NAME (Type) <u>R & E VILLARREAL MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 24, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Solomons Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Markesee Sr. Mutual, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. DATE OF REGISTRATION	
16. NAME OF FUNERAL HOME		17. ADDRESS OF FUNERAL HOME		18. CITY		19. STATE		20. COUNTY	
21. NAME OF NEXT OF KIN		22. ADDRESS OF NEXT OF KIN		23. CITY		24. STATE		25. COUNTY	
26. NAME OF WITNESS		27. ADDRESS OF WITNESS		28. CITY		29. STATE		30. COUNTY	
31. NAME OF WITNESS		32. ADDRESS OF WITNESS		33. CITY		34. STATE		35. COUNTY	
36. NAME OF WITNESS		37. ADDRESS OF WITNESS		38. CITY		39. STATE		40. COUNTY	
39. NAME OF WITNESS		40. ADDRESS OF WITNESS		41. CITY		42. STATE		43. COUNTY	
44. NAME OF WITNESS		45. ADDRESS OF WITNESS		46. CITY		47. STATE		48. COUNTY	
49. NAME OF WITNESS		50. ADDRESS OF WITNESS		51. CITY		52. STATE		53. COUNTY	
54. NAME OF WITNESS		55. ADDRESS OF WITNESS		56. CITY		57. STATE		58. COUNTY	
59. NAME OF WITNESS		60. ADDRESS OF WITNESS		61. CITY		62. STATE		63. COUNTY	
64. NAME OF WITNESS		65. ADDRESS OF WITNESS		66. CITY		67. STATE		68. COUNTY	
69. NAME OF WITNESS		70. ADDRESS OF WITNESS		71. CITY		72. STATE		73. COUNTY	
74. NAME OF WITNESS		75. ADDRESS OF WITNESS		76. CITY		77. STATE		78. COUNTY	
79. NAME OF WITNESS		80. ADDRESS OF WITNESS		81. CITY		82. STATE		83. COUNTY	
84. NAME OF WITNESS		85. ADDRESS OF WITNESS		86. CITY		87. STATE		88. COUNTY	
89. NAME OF WITNESS		90. ADDRESS OF WITNESS		91. CITY		92. STATE		93. COUNTY	
94. NAME OF WITNESS		95. ADDRESS OF WITNESS		96. CITY		97. STATE		98. COUNTY	
99. NAME OF WITNESS		100. ADDRESS OF WITNESS		101. CITY		102. STATE		103. COUNTY	